Spinraza™ (Nusinersen)

Medical Guideline Disclaimer

Property of EmblemHealth. All rights reserved. The treating physician or primary care provider must submit to EmblemHealth the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary. If there is a discrepancy between this guideline and a member’s benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and web site links are accurate at time of publication. EmblemHealth Services Company LLC, (“EmblemHealth”) has adopted the herein policy in providing management, administrative and other services to HIP Health Plan of New York, HIP Insurance Company of New York, Group Health Incorporated and GHI HMO Select, related to health benefit plans offered by these entities. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Definitions

Spinraza is a survival motor neuron-2 (SMN2)-directed antisense oligonucleotide indicated for the treatment of spinal muscular atrophy (SMA). The drug is administered intrathecally.

Spinal muscular atrophy (SMA) is neurological disease characterized by loss of motor neurons in the spinal cord and lower brain stem, resulting in severe and progressive muscular atrophy and weakness. 5q-SMA is an autosomal recessive genetic disorder caused by mutations in the SMN1 (survival motor neuron) gene that is found on chromosome 5. To develop SMA, an individual must inherit two faulty SMN1 genes, one from each parent.

- SMA Type 1 (infantile onset SMA or Werdnig-Hoffmann disease) — symptoms are present at birth or by the age of 6 months
- SMA Type 2 — onset of symptoms between the ages of 7 and 18 months and before the child can stand or walk independently
- SMA Type 3 — onset of symptoms after 18 months, and children can stand and walk independently, although they may require aids
- SMA Type 4 (adult-onset SMA or Kugelberg-Welander disease) — onset of symptoms in adulthood, and people are able to walk during their adult years.

Dosing and Administration

Spinraza Package Insert

Guideline

Spinraza is considered medically necessary for the treatment of Types I, II or III SMA when the following criteria are met.

A. Initiation therapy; all:
1. SMA diagnosis and treatment prescription by pediatric neurologist
2. Clinical documentation of 5q SMA homozygous gene mutation, homozygous gene deletion or compound heterozygote (i. or ii.)
   i. Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)
   ii. Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
3. Member is ≤ 15 years of age at start of therapy
4. Baseline exam of at least ONE of the following exams to establish baseline motor ability:
   i. Hammersmith Infant Neurological Exam (HINE) (infant to early childhood)
   ii. Hammersmith Functional Motor Scale Expanded (HFMSE)
   iii. Upper Limb Module (ULM) Test (Non ambulatory)
   iv. Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
5. Documentation of either:
   i. Genetic testing confirming no more than 2 copies of SMN2; or
   ii. SMA-associated symptoms before 6 months of age.
6. Patient is NOT dependent on either invasive ventilation or tracheostomy, OR Non-invasive ventilation for at least 12 hours per day
7. Spinraza is being prescribed by a neurologist with expertise in the treatment of SMA
8. Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures
9. Spinraza dosing is in accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 12mg for each loading dose

B. Continuation therapy beyond 6 months after initiation of therapy, and every 6 months thereafter; all (1–5):
1. SMA diagnosis and treatment prescription by pediatric neurologist
2. Clinical documentation of 5q SMA homozygous gene mutation, homozygous gene deletion or compound heterozygote (i. or ii.)
   i. Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)
   ii. Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])
3. No respiratory dependency on either:
   a. Invasive ventilation or tracheostomy
   b. Non-invasive ventilation for a period ≥ 6 hours per day
4. Prevention of permanent ventilation (≥ 16 hours ventilation/day continuously for> 21 days in absence of an acute reversible event or tracheostomy)
5. Clinical documentation delineates positive therapeutic response to Spinraza, from pretreatment baseline, as demonstrated by any of the measurement tools (a, b, c, or d, as appropriate) (Physician evaluation must occur ≤ 1 month prior to request)
   a. Hammersmith Infant Neurological Examination (HINE) milestones (for infants 2 months–2 years of age (i and ii):
      i. One of the following:
1. Improvement, or maintenance of previous improvement, of at least 2 point (or maximal score) increase in ability to kick
2. Improvement, or maintenance of previous improvement, of at least 1 point increase in any other HINE milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

   ii. One of the following:
      1. Improvement or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)
      2. Member achieved and maintained any new motor milestones that is otherwise not expected (e.g., sit unassisted, stand, walk)

b. Hammersmith Functional Motor Scale (HFMSE): (i. or ii.)
   i. Improvement, or maintenance of previous improvement, of at least a 3 point increase in score from pretreatment baseline
   ii. Member has achieved and maintained any new motor milestone from pretreatment baseline that is otherwise not expected

c. Upper Limb Module (ULM): (i. or ii.)
   i. Improvement or maintenance of previous improvement of at least a 2 point increase in score from pretreatment baseline
   ii. Member has achieved and maintained any new motor milestone from pretreatment baseline that is otherwise not expected

d. Children’s Hospital of Philadelphia (CHOP) infant Test of Neuromuscular Disorders (INTEND): (i. or ii.)
   i. Improvement, or maintenance of previous improvement, of at least a 4 point increase in score from pretreatment baseline
   ii. Member has achieved and maintained any new motor milestone from pretreatment baseline that is otherwise not expected

**Quantity Limit:**
- Initial: 4 vials for the first 58 days
- Maintenance: 1 vial every 120 days

**Duration of Approval:**
- Initial: 6 months
- Renewal: 6 months

**Limitations/Exclusions**
Spinraza is not considered medically necessary for any indication other than as listed above.

*Emblem Health considers Spinraza not medically necessary for individuals in current treatment or previously treated with gene therapy (e.g. Zolgensma) for SMA.

**Applicable Procedure Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2326</td>
<td>Injection, nusinersen, 0.1 mg (Eff. 01/01/2018)</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified drugs (prior to 1/1/2018)</td>
</tr>
</tbody>
</table>
Applicable Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>G12.0</td>
<td>Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]</td>
</tr>
<tr>
<td>G12.1</td>
<td>Other inherited spinal muscular atrophy</td>
</tr>
<tr>
<td>G12.8</td>
<td>Other spinal muscular atrophies and related syndromes</td>
</tr>
<tr>
<td>G12.9</td>
<td>Spinal muscular atrophy, unspecified</td>
</tr>
</tbody>
</table>

Revision History

7/18/19 – Added statement: Emblem Health considers Spinraza not medically necessary for individuals in current treatment or previously treated with gene therapy (e.g. Zolgensma) for SMA

References

Med Lett Drugs Ther. 2017 Mar 27;59(1517):50-52. Nusinersen (Spinraza) for spinal muscular atrophy.


Specialty matched clinical peer review.